Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
WILLIAM J KOWALSKI

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-14-0404-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
October 01, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a DDE carrier failed to pay – stated on claim – coding wrong attached is copy of coding as taught in seminar Refiled 8/20/13 carrier ignored request for reconsideration Request payment f required amount without fail + plus interest."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on October 9, 2013. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 12, 2013	CPT Code 99456-W5 and 99456-W5-WP	$650.00	$350.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
   - 16 - Claim/service lacks information which is needed for adjudication
   - BL – This bill is a reconsideration of a previously reviewed bill, allowance amounts do not reflect previous amounts

Issues

1. Did the requestor bill the disputed services in dispute appropriately?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 states (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:

   (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

   (C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection.

   (3) The following applies for billing and reimbursement of an MMI evaluation.

   (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350.

   (4) The following applies for billing and reimbursement of an IR evaluation.

   (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.

   (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

   (i) Musculoskeletal body areas are defined as follows:

   (I) spine and pelvis;

   (II) upper extremities and hands; and,

   (III) lower extremities (including feet).

   (ii) The MAR for musculoskeletal body areas shall be as follows.

   (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

   (iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR.

   Review of the requestor's submitted documentation finds the examining doctor addressed maximum medical improvement and impairment rating to one body area using Diagnosis Related Estimate (DRE) method. The requestor billed for the disputed service performed on July 12, 2013 with CPT Code 99456-W5 in the amount of 300.00 with one unit billed and 99456-W5-WP in the amount of $350.00 with one unit billed. CPT Code 99456-W5 is not supported. The total MAR for the services performed are $500.00.

2. The respondent issued payment in the amount of $0.00. Based upon the documentation submitted, additional reimbursement in the amount of $350.00 is recommended for CPT Code 99456-W5-WP.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $350.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $350.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	6/27/14 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.